

EDUCATION POLICY COMMITTEE - IMPACT OF STUDENTS WHO EXPERIENCE BEHAVIORAL HEALTH CRISIS - BACKGROUND MEMORANDUM

Senate Concurrent Resolution No. 4004 (2019) directs the Legislative Management to study the impact of students who experience behavioral health crisis or who engage in intense and aggressive behavior for communication purposes, both of which result in behaviors that make learning environments unsafe for other students, teachers, and other school personnel, and the need to implement a uniform reporting system.

BACKGROUND

Study Directive and Legislative History

Senate Concurrent Resolution No. 4004, as introduced, directed a Legislative Management review of the impact of violent, disruptive, and inappropriate behavior within the educational environment perpetrated by students against other students, teachers, and other school personnel, and the need to implement a uniform reporting system. The resolution was amended to replace "violent, disruptive, and inappropriate behavior within the educational environment perpetrated by students against" with "students who experience behavioral health crisis or who engage in intense and aggressive behavior for communication purposes, both of which result in behaviors that make learning environments unsafe for...." The amendment was offered to address concerns the original language of the study resolution could be construed as negative and offensive to students who have behavioral issues.

Testimony on the resolution indicated students are increasingly developing behavioral issues at a younger age, which creates challenges in the learning environment for students and educators alike. According to survey data collected in 2017 by Greenway Strategy Group for a contracted project on behalf of the Department of Public Instruction (DPI), "behavioral health issues among students" was one of the top challenges faced in schools across the state. The data also indicated administrators felt increased support for behavioral health issues would improve student achievement. According to the testimony, it is important to distinguish among the terms and phrases used in the behavioral health discipline such as behavioral health, learning disabilities, mental illness, and special education. While some of the conditions may present simultaneously and contribute to the issues faced by students, the terms and phrases have different meanings and cannot be used interchangeably.

One of the goals of the study is to develop the consistent collection of data regarding behavioral health issues in schools. Testimony also indicated a desire to determine best practices from around the state and to develop uniform definitions in order for schools to be able to start adequately addressing student behavioral health issues.

Representatives of North Dakota United, the North Dakota Council of Educational Leaders, the North Dakota School Boards Association, individual educators in the state, DPI, regional education associations, the Arc of North Dakota, the North Dakota Federation of Families for Children's Mental Health, Mental Health America of North Dakota, and Designer Genes of North Dakota provided testimony in support of the study resolution. The North Dakota Protection and Advocacy Project provided neutral testimony. The committee received no opposition testimony.

BEHAVIORAL HEALTH

North Dakota Law and Relevant Legislation

The study directive and corresponding legislative history was unclear regarding whether the study of "the impact of students who experience behavioral health crisis..." was intended to only study student behaviors in the classroom or if it was meant to study student behavioral health issues as defined by the Department of Human Services (DHS) and the North Dakota Century Code.

Section 50-06-01 defines "behavioral health" as the planning and implementation of preventive, consultative, diagnostic, treatment, crisis intervention, and rehabilitative services for individuals with mental, emotional, or substance use disorders, and psychiatric conditions. Pursuant to its website, DHS defines behavioral health further as "a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health conditions affect people from all walks of life and all age groups."

Senate Bill No. 2048 (2015) created Section 15.1-13-35, which requires candidates for teacher licensure to demonstrate competencies in youth mental health before the Education Standards and Practices Board may issue a teaching license. The competencies must include an understanding of the prevalence and impact of youth mental health disorders on family structure, education, juvenile services, law enforcement, and health care and treatment

providers; knowledge of mental health symptoms, social stigmas, risks, and protective factors; and awareness of referral sources and strategies for appropriate interventions.

Senate Bill No. 2048 also created Section 15.1-07-34, which requires at least 8 hours of professional development on youth behavioral health to teachers and administrators every 2 years. The section encourages ancillary and support staff to participate in the professional development. The section originally required professional development training on "youth mental health," but the section was amended in 2017 to replace "mental health" with "behavioral health." Testimony indicated behavioral health is a broader term than mental health and encompasses anything related to basic wellness. The section requires school districts to conduct an annual needs assessment and designate the hours of training from several categories based on the results of the needs assessment. The categories from which to be designated include understanding the prevalence and impact of youth behavioral health wellness on family structure, education, knowledge of behavioral health symptoms and risks, awareness of referral sources and evidence-based strategies for appropriate interventions, and evidence-based strategies to reduce risk factors for students. The section also requires school districts to report the hours to the Superintendent of Public Instruction, and requires the Superintendent to collaborate with regional education associations to disseminate information and training materials to school districts. Senate Bill No. 2149 (2019) further amended Section 15.1-07-34 to require each school within a district to designate an individual as a behavioral health resource coordinator, and requires the Superintendent to maintain the contact information of each person.

Section 50-06-43 created by Senate Bill No. 2038 (2017), provides for the task force on children's behavioral health. The purpose of the task force is to assess and guide efforts within the children's behavioral health system to ensure a full continuum of care is available in the state. The task force also is responsible for making recommendations regarding children's behavioral health services, identifying recommendations and strategies to address gaps and needs in the children's behavioral health system, engaging stakeholders, and providing a report to the Governor and the Legislative Management every 6 months regarding the status of the task force's efforts.

Senate Bill No. 2342 (2017) created a task force on the prevention of sexual abuse of children. The task force was directed to gather information concerning child sexual abuse throughout the state and develop recommendations to reduce child sexual abuse. The task force was required to submit a final report to the Governor and the Legislative Management with recommendations following the 2017-18 interim. One of the findings of the task force in its November 2018 final report was evidence-based, age-appropriate education is a benefit for children as it empowers them to discuss feelings of discomfort and assists them in identifying helpers that can interrupt and end the abuse. The task force also found teachers and parents should receive education and status notifications that enable everyone to speak a common language and monitor the health and safety of children. The task force recommended the creation of a committee to serve for at least 5 years and build on the work of the task force among other specific recommendations.

House Bill No. 1237 (2019) created a task force on the prevention of sexual abuse of children. The task force, which will sunset on September 30, 2024, was established to develop and implement a comprehensive statewide approach to the prevention of child sexual abuse, including appropriate policies, funding, staffing, resources, and programming. One of the focuses of the task force is to implement the recommendations of the November 2018 final report of the task force on the prevention of sexual abuse of children. Additional focuses of the task force are to increase child sexual abuse education for children, increase interagency data collection, and increase trauma-informed services for children. The task force, which is to be convened by the executive director of DHS, is required to submit a report and recommendations to the Governor and the Legislative Management before July 1 of each even-numbered year.

House Bill No. 1262 (2019) would have required the Attorney General to encourage and promote the use of statewide and locally selected school safety and crisis reporting programs. The reporting programs would have been tailored to target incidents of bullying and physical or sexual abuse in schools. The bill also would have allowed the Attorney General to conduct outreach and promote awareness of the reporting programs. The bill failed to pass the Senate.

Senate Bill No. 2266 (2019) would have required school districts to adopt a policy regarding the use of restraint and seclusion methods by school district personnel on students. The bill would have required school district personnel to be certified and trained annually in the safe and effective use of physical restraints and comprehensive positive behavioral interventions and supports to prevent and reduce instances of dangerous behaviors. The bill also would have required documentation and the collection of data regarding each instance of the use of restraint or seclusion. The bill would have required the collected data be reported to the Superintendent of Public Instruction and the United States Department of Education Office for Civil Rights, and disseminated to the public. The bill failed to pass the Senate.

Task Force on Children's Behavioral Health

As previously discussed, the task force on children's behavioral health was created by Senate Bill No. 2038 (2017). The task force is required to report to the Governor and the Legislative Management every 6 months regarding the status of the task force's efforts. To date, the task force has met 10 times between April and December 2018. The task force, which provided periodic reports to the 2017-18 interim Health Services Committee, includes representatives of the State Department of Health, DHS, Indian Affairs Commission, DPI, Department of Corrections and Rehabilitation, and the Protection and Advocacy Project. The task force developed and reported recommendations in several areas.

Among the recommendations of the task force was to seek funding from the 2019 Legislative Assembly to provide competitive grants to school districts or schools that adopt and implement comprehensive restraint and seclusion policies and practices and provide sufficient assurances and action plans to ensure the establishment of safe and appropriate student behavior management and staff intervention policies and practices. The task force also recommended the development of a plan of action to advance the establishment of the state and regional coordination structure, including the development of broad governance interagency agreements, required statutory changes, potential incremental or piloted deployment models, and shared agency resources or state appropriations proposals.

In addition, the task force recommended a resolution of support for the continuation and expansion of the State Department of Health Suicide Prevention program. The task force reported it would compile a list of the various agencies' suicide prevention outreach efforts to assess how collaboration among agencies may improve the combined effect of these efforts across their respective venues.

Reporting and Resources

Pursuant to the required behavioral health training for teachers and administrators in Section 15.1-07-34, DPI, in collaboration with the Mid-Dakota Education Cooperative, created the Trauma Sensitive Schools (TSS) training initiative. According to the DPI website, over 6,600 North Dakota educators have undergone the training. The training is intended to motivate and guide schools to examine and transform policies and practices, educational strategies, professional development, and community relationships to create an environment and community that is safe, caring, and respectful and where all children can learn to their capacity. The training is designed to be provided over three, 2-hour professional development sessions. The training consists of five modules that range from creating an awareness of trauma and its effects on learning to exploring trauma-informed practices. According to the Mid-Dakota Education Cooperative, participants in TSS training learn how to understand the term child traumatic stress and know what types of experiences constitute childhood trauma; understand the impact of trauma on the brain development and behavior of children; learn how the impact of traumatic stress can be prevented or mitigated by the use of trauma-informed responses and strategies; identify "secondary traumatic stress" and learn strategies for "taking care of you;" and describe a framework for creating a "trauma-informed" culture.

According to DPI, the United States Department of Education requires DPI to report data on truancy rates annually; the frequency, seriousness, and incidence of violence; and drug-related offenses resulting in suspensions and expulsions in all elementary, middle and secondary schools in the state. The information is required to be reported to the state on a school-by-school basis. All public, nonpublic, and Bureau of Indian Education schools receiving federal Title I funds are required to file the report. According to the DPI website, the number of violent and drug-related incidents resulting in suspension or expulsion in North Dakota schools each school year was:

- 2013-14 - 1,461 incidents.
- 2014-15 - 1,385 incidents.
- 2015-16 - 2,021 incidents.
- 2016-17 - 2,332 incidents.
- 2017-18 - 2,610 incidents.

RECENT STUDIES

While not specific to children or students, several recent legislative studies related to behavioral health needs have been conducted.

2013-14 Interim

Pursuant to Senate Bill No. 2243 (2013), the 2013-14 interim Human Services Committee studied behavioral health needs, including consideration of behavioral health needs of youth and adults and consideration of access,

availability, and delivery of services. The study included input from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions. The committee contracted with Schulte Consulting, LLC, to assist with the behavioral health needs study. The consultant's report identified six primary opportunities to better address behavioral health needs of youth and adults in North Dakota--service shortages, workforce expansion, insurance coverage changes, changes to the structure and responsibilities of DHS, communication improvement, and data collection and research expansion. In 2015, the Legislative Assembly approved a number of bills related to behavioral health, including Senate Bill No. 2048, which is discussed earlier in this memorandum.

2015-16 Interim

The 2015-16 interim Human Services Committee, pursuant to Section 7 of Senate Bill No. 2048 (2015), continued the study of behavioral health needs. The study included consideration of behavioral health needs of youth and adults and access, availability, and delivery of services. The study included a review of services related to autism spectrum disorder and input from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions. The study included monitoring and reviewing strategies to improve behavioral health services implemented pursuant to legislation enacted by the 2015 Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee. As part of its study, the committee reviewed behavioral health-related information, including an overview of behavioral health; an overview of a behavioral health system of care; key legal obligations related to behavioral health services; the DHS behavioral health services delivery system, including information on substance abuse disorder system, regional intervention and emergency services continuum, adult behavioral health services, children's behavioral health services; and reports on mental health training for school districts, involuntary treatment laws, the future role of human service centers and the State Hospital, the behavioral health needs assessment, and other committee information, including:

- Behavioral health definitions;
- Role and challenges of residential treatment services;
- Substance abuse treatment needs;
- A summary of information provided by the Council of State Governments relating to behavioral health and the criminal justice system;
- Federal Mental Health Parity and Addiction Equity Act, including the legal framework of the Act, the implications of the Act for the state, and requirements of the Act;
- Current behavioral health issues under consideration at the federal level;
- The need for more programs and services that address the unmet needs of consumers and families in the state, including consumer-centered support programs and a formal one-on-one peer support program;
- The need to address the addiction counselor workforce shortage, including supporting professional development for workers and assisting treatment providers with offering additional services;
- The definition of addiction counseling pursuant to Section 43-45-01;
- The need for a continuum of care model for mental health-related services that would be similar to those of the state's developmental disability system; and
- The need for additional behavioral health services.

Key Legal Obligations Related to Behavioral Health Services

As part of its study, the interim Human Services Committee received information regarding legal obligations related to behavioral health services from the Bazelon Center for Mental Health Law, Washington D.C. The legal framework for behavioral health services includes the United States Supreme Court ruling in the 1999 *Olmstead v. L.C.* case; Medicaid and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; the federal Mental Health Parity and Addiction Equity Act of 2008; and the federal Affordable Care Act of 2010. In *Olmstead*, the Court determined the Americans with Disabilities Act requires states to provide community-based treatment for persons with mental disabilities when a state's treatment professionals determine such placement is appropriate, affected persons do not oppose such treatment, and placement can be reasonably accommodated, considering resources available in the state and the needs of others with mental disabilities. The ruling protects at-risk people with disabilities who live in the community but have undertreated behavioral health conditions that place them at

serious risk of institutionalization. In addition to state institutions, the ruling also applies to privately owned and operated facilities in the state's service delivery system. States must provide EPSDT services to Medicaid-eligible children and youth under age 21. States also must provide necessary health care, diagnostic services, treatment, and other measures to correct physical and mental illnesses and conditions regardless of whether services are specifically covered in the state's Medicaid plan. Early and Periodic Screening, Diagnostic, and Treatment also requires states to provide intensive home-based services to Medicaid-eligible children with a disability that affects behavior. The federal Substance Abuse and Mental Health Services Administration determined these services include intensive care coordination, peer services, intensive in-home services, respite care services, mobile crisis response and stabilization services, flex funds, trauma-informed treatments, mentoring, supported employment, and consultative services. The federal Mental Health Parity and Addiction Equity Act of 2008 provides private health insurance plans that cover services for individuals with mental health or substance abuse disorders must be equitable with coverage for other health conditions; limits on coverage for these plans are not allowed to be stricter for behavioral health services than for other services; copayments and deductibles are not allowed to be higher for behavioral health services than for other services; and a plan that includes out-of-network coverage for physical health care must include out-of-network coverage for behavioral health care.

The 2017 Legislative Assembly approved a number of bills related to behavioral health. House Bill No. 1040 (2017) required DHS to adopt rules for an evidence-based alcohol and drug education program for certain individuals under 21 years of age, and appropriated \$350,000 for a children's prevention and early intervention behavioral health services pilot project (\$150,000); peer-to-peer support services (\$100,000); and family-to-family support services (\$100,000). A list of major bills relating to behavioral health is included in a memorandum prepared for the 2015-16 interim Human Services Committee entitled [History of Behavioral Health Services in North Dakota](#).

2017-18 Interim

Pursuant to House Bill No. 1012 (2017), the 2017-18 interim Health Services Committee studied state and federal laws and regulations relating to the care and treatment of individuals with developmental disabilities or behavioral health needs. The study followed previous legislative studies from the 2013-14 interim and 2015-16 interim Human Services Committees' studies of behavioral health needs. The study included the state's services and delivery systems, including whether changes are necessary to maintain compliance with state and federal laws and regulations; efforts by other states to comply with the 1999 *Olmstead v. L.C.* case, including the planning and implementation process for any new programs; community- and noncommunity-based services, including the costs and effectiveness of services; noncompliance with state and federal laws and regulations, including a review of the fees and penalties for noncompliance; a comparison of voluntary and involuntary compliance with state and federal laws and regulations, including a review of long-term costs and effectiveness; the impact of implementation and expansion of selected programs that were added to address unmet needs, including the impact on costs and effectiveness of new programs; needed changes to address noncompliance and a timeline for completing changes; data on the number of individuals who would be impacted by voluntary compliance efforts, and data on the type of services that may need changing, including housing, peer counseling, outpatient treatment, crisis line access, and transportation services; and an evaluation of the funding, mission, and caseload at the Life Skills and Transition Center, including the center's transition plan and number of clients eligible for community placement.

The Behavioral Health Division of DHS contracted with the Human Services Research Institute (HSRI) to conduct a review of the state's behavioral health systems. The institute's final report entitled *North Dakota Behavioral Health Systems Study - Final Report* was submitted in April 2018. The report provided 65 specific recommendations in 13 areas. The 13 areas include developing a comprehensive implementation plan; investing in prevention and early intervention; ensuring individuals have timely access to appropriate behavioral health services; expanding the types of outpatient and community-based services; enhancing and streamlining the system of care for children and youth with complex needs; continuing to implement and refine the criminal justice system strategy; engaging in targeted efforts to recruit and retain a qualified and competent behavioral health workforce; continuing to expand the use of telebehavioral health interventions; ensuring the system reflects its values of person-centered, cultural competency, and trauma-informed approaches; encouraging and supporting communities to share responsibility with the state for promoting high-quality behavioral health services; partnering with tribal nations to increase health equity for American Indian populations; diversifying and enhancing funding for behavioral health; and conducting ongoing, systemwide, data-driven monitoring of need and access.

The department also contracted with the institute to develop an implementation plan for the study. The Behavioral Health Division and HSRI are working with the North Dakota Behavioral Health Planning Council to implement the study recommendations. The North Dakota Behavioral Health Planning Council is a required advisory council created pursuant to the federal State Comprehensive Mental Health Services Plan Act of 1986, Pub. L. 99-660. The council monitors, reviews, and evaluates the allocation and adequacy of mental health services within North Dakota.

STUDY APPROACH

In conducting this study, the committee may wish to:

- Receive testimony from DPI, teachers, administrators, and other education stakeholders to determine the scope of the study and specific data regarding the type and frequency of student behavioral health incidents occurring in schools across the state;
- Receive information from education stakeholders to determine uniform definitions and best practices for student behavioral health issues;
- Receive testimony from DHS and DPI to determine information, data, and logistics required to implement a uniform reporting system; and
- Consult with and seek additional information from organizations such as the task force on children's behavioral health, the National Conference of State Legislatures, the Education Commission of the States, the North Dakota Behavioral Health Planning Council, and HSRI.